



Kirsten Van Nostran, MS, L.Ac.  
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3237 State Rd. Cuyahoga Falls, OH 44223  
(330) 929-4334 FAX (330) 929-4353  
Website:www.summitacupuncture.com

### **OFFICE POLICY**

During your first visit please allow 1 and a half hours for your treatment. Follow-up treatments generally take between 30 minutes to an hour. Please arrive well fed, rested, and not under the influence of alcohol and drugs in order to ensure the best possible treatment.

Please allow time for your healthcare and respect the needs of other patients by arriving on time. **If you need to cancel an appointment, please give 24 hours notice so that other patients may be informed of an available treatment time.** Late appearances may result in insufficient time to complete a treatment session. The next available appointment will be offered to you. Lates and no shows will be charged for the appointment, although an emergency is reasonable and understandable. Payment is due at the time of service.

Any and all questions about treatment, billing, and appointments are welcome. We may be reached at 330.929.4334, if we are unable to answer the phone please leave a message, phone number, and a good time to call and we will return your call as soon as possible.

Please fill out the enclosed forms and bring with you on your first visit.



**DIRECTIONS**

**3237 State Rd, Cuyahoga Falls, Ohio 44223**

**330-929-4334**

**RTE 8 NORTH**

Take Rte 8 North to the Graham Rd Exit. Turn **Left** off the exit ramp onto Graham Rd. Follow Graham road to Bath Rd. Turn **Right** onto Bath Rd. There's a **Right** hand turn lane that turns into On Tap Plaza. We're in the plaza facing Bath Rd next to North Hampton Primary Care.

**RTE 8 SOUTH**

Take Rte 8 to the Graham Rd exit. Turn **Right** off the exit ramp onto Graham Road. Follow Graham road to Bath Rd. Turn **Right** onto Bath Rd. There's a **Right** hand turn lane that turns into On Tap Plaza. We're in the plaza facing Bath Rd next to North Hampton Primary Care. .

**77 NORTH**

Take 77 North to Route 8 North. Take Rte 8 North to the Graham Rd Exit. Turn **Left** off the exit ramp onto Graham Rd. Follow Graham road to Bath Rd. Turn **Right** onto Bath Rd. There's a **Right** hand turn lane that turns into On Tap Plaza. We're in the plaza facing Bath Rd next to North Hampton Primary Care.

Updated 7.29.2011

## PATIENT INFORMATION

NAME(LAST,MIDDLE,FIRST)	DATE
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AGE	DATE OF BIRTH	SEX: MALE FEMALE	MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP

EMPLOYED BY		
EMPLOYER'S ADDRESS		
CITY	STATE/ZIP	PHONE

SOCIAL SECURITY NUMBER
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SPOUSE'S NAME
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CONTACT IN CASE OF EMERGENCY	RELATIONSHIP	PHONE
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REFERRED BY
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MEDICAL DOCTOR'S NAME	
ADDRESS	PHONE

ADDITIONAL INFORMATION/NOTES:
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### CANCELLATION POLICY:

Summit Acupuncture requests that you give 24 hours notice before re-scheduling or canceling an appointment. Patients who do not show for a scheduled appointment will be charged for the missed appointment.

### PAYMENT POLICY:

Summit Acupuncture requests payment at the time of service, with the exception of coverage with Worker's Compensation. We accept cash, checks, Visa,Master Card, and Discover. Checks may be made out to Summit Acupuncture. We will provide patients with a superbill to submit to their insurance company if necessary.

I, \_\_\_\_\_, certify that I have read and understood the statements above and agree to  
(Print Name)  
abide by them.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## SUMMIT ACUPUNCTURE - MEDICAL HISTORY

MAJOR COMPLAINT/HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU RECEIVED TREATMENT FOR THIS CONDITION? YES NO	IF YES, BY WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND (S) OF TREATMENT?
WHAT WERE THE RESULTS OF THE TREATMENT?	

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: MEDICATION	if you need more room, please use the back of this page DOSAGE	FOR HOW LONG
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY VITAMINS HERBS OR SUPPLEMENTS YOU ARE TAKING: SUPPLEMENT	if you need more room, please use the back of this page DOSAGE	FOR WHAT CONDITION?
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	if you need more room, please use the back of this page PROBLEM/SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, EMOTIONAL, ETC)

\_\_\_\_\_

SIGNIFICANT ILLNESSES (PLEASE CIRCLE ALL THAT APPLY)

Arthritis	Connective Tissue Disease	Hypertension	Thyroid Disease
Asthma	Diabetes	Kidney Stones	Venereal Disease
Autoimmune Disease	Gallstones	Rheumatic Fever	Stroke
AIDS/HIV	Heart Disease	Ruptured Appendix	Multiple Sclerosis
Cancer	Hepatitis	Seizures	Tuberculosis

**Please circle any symptoms you currently have or have had within the last year**

**General**

Chills  
Low energy  
Dizziness  
Allergies  
Fatigue  
Fever  
Excessive Thirst  
Nervousness  
Numbness  
Sweat spontaneously  
Night sweating  
Lack of sweating  
Aversion to heat  
Aversion to cold

**Head & Neck**

Blurred vision  
Heaviness in the head  
Headache  
Phlegm in throat  
Cataract  
Double Vision  
Dry eyes  
Night blindness  
Macular degeneration  
Earaches  
Eye pain/strain  
Corrected vision  
Nasal obstruction  
Nasal discharge  
Loss of sense of smell  
Hearing loss  
Hoarseness  
Nosebleeds  
Recurrent sore throat  
Red/inflamed eye  
Ringing in ears  
Sores on lips  
Sores on tongue  
Bleeding gums  
TMJ  
Dry mouth  
Excessive saliva  
Post-nasal drip  
Swollen glands  
Difficulty swallowing  
Taste change

**Respiratory**

Asthma  
Hay fever  
Persistent cough

Coughing of blood  
Shortness of breath  
Recurrent bronchitis  
Phlegm production  
Dry cough  
Wheezing  
Difficulty inhaling  
Difficulty exhaling

**Cardiovascular**

Chest pain  
High blood pressure  
Low blood pressure  
High cholesterol  
Blood clots  
Heart valve abnormality  
Irregular heart beat  
Poor circulation  
Swelling of ankles  
Varicose veins  
Hypochondriac pain  
Distention in chest or ribs  
Heart palpitations  
Pacemaker  
Cold hands/feet

**Gastrointestinal**

Abdominal Pain  
Bloating  
Belching  
Gas  
Constipation  
Diarrhea/loose stool  
Bloody stools  
Black stools  
Anal itching/burning  
Mucous in stool  
Anal fissures  
Incomplete evacuation  
IBS  
Colitis  
Gout  
Gallstones  
Heartburn/reflux  
Hemorrhoids  
Indigestion  
Poor appetite  
Extreme appetite  
Cravings  
Dieting  
Tired after eating  
Bulimia

Irritability or low energy  
between meals  
Stomachache  
Nausea  
Vomiting  
Vomiting blood

**Diet/Lifestyle**

Vegetarian  
Vegan  
Raw foods diet  
Low fat diet  
High protein/low carb  
Dairy milk cheese  
Eggs  
Artificial sweeteners  
Spicy  
Sweet  
Sour  
Salty  
Cold drinks  
Hot drinks  
Extreme thirst  
Thirst with no desire to drink  
Healthy Diet  
Eat much fried foods  
Eat much meat  
Smoke Cigarettes  
Drink alcohol  
Drink coffee  
Use Drugs  
Eat a lot of sweets  
Take steroids  
Exercise regularly  
Exercise excessively

**Weight**

Underweight  
Normal for height  
Overweight  
Very overweight

**Genitourinary**

Dilute urine  
Dark urine  
Blood in urine  
Cloudy urine  
Burning Urination  
Scanty urine  
Profuse urine  
Frequent urination  
Poor bladder control

**Genitourinary Con't.**

Urgency to urinate  
Incomplete urination/retention  
Wake frequently to urinate  
Kidney stones  
Decreased sexual desire

**Musculoskeletal**

Pain weakness numbness in:  
Arms  
Feet  
Hands  
Joints  
Legs  
Hips  
Neck  
Shoulders  
Spine  
Knee  
Difficulty walking  
Tendonitis  
Swelling  
Arthritis  
Limited range of motion  
Vertebral disc degeneration  
Osteoporosis  
Carpal tunnel  
Pain all over  
Cold limbs  
All over weakness  
Broken bones

**Skin**

Thick skin  
Thin skin  
Broken blood vessels  
Blood not clotting  
Bruise easily  
Discoloration  
Bags under eyes  
Lumps underarm  
Dry skin  
Acne  
Brittle nails  
Premature gray hair  
Dry, brittle hair  
Hair falling out  
Rashes/Hives  
Eczema  
Psoriasis  
Fungal infections

**Neurologic**

Fainting  
Convulsions

Handwriting change  
Paralysis  
Stroke  
Seizures  
Tremor  
Recent clumsiness  
Drowsiness  
Vertigo

**Emotional**

Irritability  
Anxiety  
Depression  
Poor memory  
Death of someone close  
Job stress  
Recent divorce  
Family Stress  
Financial set back  
Currently in therapy  
Seasonal mood disorder  
Easily stressed  
Often feel angry  
Troubling dreams  
Cry uncontrollably  
Feel sad a lot  
Forgetful  
Mind not clear  
Much fear  
Unrestrained joy  
Terrors  
Difficulty expressing emotions

**Sleep**

Fall asleep easily  
Lie in bed with eyes open  
Wake at specific times  
Wake repeatedly  
Wake frequently to urinate  
Wake not feeling rested  
Use drugs or supplements to fall asleep

**Men Only**

Genital pain  
Impotence  
Genital sores  
Lump in testicles  
Penis discharge  
Nocturnal emission  
Low sexual energy  
Prostate problems  
Weak urinary stream  
Herpes

**Women Only**

Abnormal pap smear  
Bleed between periods  
Irregular periods  
Heavy periods  
< 25 day cycle  
>35 day cycle  
Endometriosis  
Painful periods  
Premenstrual tension  
Breast lumps  
Contraceptives  
Sores on genitalia  
Low sexual energy  
Vaginal discharge  
Menopausal  
Uterine prolapse  
Facial hair  
May be pregnant  
Abortion  
Miscarriage  
Live birth(s)  
Breast cancer  
Ovarian cancer  
Fibroids  
Candida/Yeast  
Herpes  
Human Papilloma Virus  
STD history  
Fibrocystic breast  
Pain at ovulation  
Acne with period  
Headaches with period  
Constipation/Diarrhea with period  
Emotional changes with period

Age menses began \_\_\_\_\_  
Age ended \_\_\_\_\_  
Date of last OB/GYN exam \_\_\_\_\_

\_\_\_\_\_   
Date of last menstrual  
Period \_\_\_\_\_  
Hysterectomy - partial full

Periods last \_\_\_\_\_ days  
Usual number of days  
between periods \_\_\_\_\_

Menstrual flow:  
Clotting  
Brownish  
Watery, thin and bright red  
Normal red  
Flooding and trickling  
Stop and start flow



## NOTICE OF PRIVACY POLICY

The Health Insurance Portability and Accountability Act (HIPAA) requires strict privacy regulations in all health care settings. Summit Acupuncture is dedicated to the privacy and confidentiality of our patients. Standards have been set in place to protect all patients' privacy within the acupuncture practice. We recognize that it is sometimes necessary to use or release patient' protected health information (PHI) for purposes of providing treatment, obtaining payment for health care bills or to conduct health care operations of Summit Acupuncture.

The Privacy Officer at Summit Acupuncture is Kirsten Van Nostran MS L.Ac.. At any time you may request, in writing, to know to whom your PHI has been disclosed for the above purposes. If you feel there has been a breach of privacy, the Privacy Officer is to be notified. You will not be penalized or retaliated against for filing this complaint.

### **Your Rights Under the Privacy Policy**

1. You have the right to inspect and/or copy your medical information that may be used to make decisions about your care. This most commonly includes medical and billing records, but not psychotherapy notes. In order to inspect and/or copy your medical information, a request must be submitted in writing to the Privacy Officer. If you request a copy of us, we may charge a fee for copying costs, as well as mailing supplies or postage as applicable.
2. You have the right to request a list of the disclosures that we have made of medical information about you. This does not include information submitted to your insurance company for billing. To request a list of these disclosures, a written request must be submitted to the Privacy Officer.
3. You have the right to limit the medical information we disclose to someone who is involved in your case or payment for your care. See the box below for further details.

Please note that Summit Acupuncture uses the phone number(s) given to us by you for purposes of appointment reminder calls, contacting you about test results, and general health care options. You may, however, specify with whom we speak, and at what phone number, when communicating labs, tests, and other medically – specific information. Most people designate their spouses or a close relative as another person with whom we may discuss medical information. **If you do not designate any specific person(s), we will only be able to talk with you about these matters.**

We are required to have written acknowledgement that you have been notified of our privacy policies. We will be more than happy to provide a copy for you as well. You will be asked to sign the following consent:

I consent to the use or disclose of my protected health information by Summit Acupuncture for the purpose of providing treatment, obtaining payment for health care bills or to conduct health care operations of Summit Acupuncture.

This authorization shall be in force and effect for twelve months from the date recorded below, at which time this authorization to use or disclose PHI expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Summit Acupuncture’s Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed be protected by federal or state law.

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Please note that Summit Acupuncture uses the phone number(s) given to us as demographics are updated by you yearly. We use that number to call you for appointment reminders in addition to general health care operations. You may, however, specify with whom we speak and at what phone number, when communicating medically specific information.

**To ensure that your confidentiality is protected at the standard you expect, please complete the following:**

I  **authorize**  **do not authorize** Summit Acupuncture to disclose PHI to: (Please describe any that apply)

My Spouse \_\_\_\_\_

My Family Members \_\_\_\_\_

Patient's Non-Custodial Parent \_\_\_\_\_

Other \_\_\_\_\_

I  **authorize**  **do not authorize** Summit Acupuncture to leave messages which may contain PHI at the following phone numbers:

Home (\_\_\_\_ \_\_ \_\_) \_\_\_\_ \_\_\_\_ -- \_\_\_\_ \_\_\_\_ \_\_\_\_

Work (\_\_\_\_ \_\_ \_\_) \_\_\_\_ \_\_\_\_ -- \_\_\_\_ \_\_\_\_ \_\_\_\_

Cell (\_\_\_\_ \_\_ \_\_) \_\_\_\_ \_\_\_\_ -- \_\_\_\_ \_\_\_\_ \_\_\_\_

Other (\_\_\_\_ \_\_ \_\_) \_\_\_\_ \_\_\_\_ -- \_\_\_\_ \_\_\_\_ \_\_\_\_

I prefer to be contacted **by mail only** with anything containing PHI at the following address:

I consent to the use or disclosure of my protected health information by Summit Acupuncture for the purpose of providing treatment, obtaining payment for health care bills or to conduct health care operations of Summit Acupuncture.

This authorization shall be in force and effect for twelve months from the date recorded below, at which time this authorization to use or disclose PHI expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Summit Acupuncture's Privacy Officer. I understand that a revocation is not effective to the extent that my acupuncturist has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

By signing below I acknowledge that I have received a copy of the Summit Acupuncture's Notice of Privacy Policies. This acknowledgement is valid for:  myself  the following child (for whom I am legally responsible):

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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### INFORMED CONSENT & DIAGNOSTIC EXAM

I consent to acupuncture and other procedures by the licensed acupuncturist affiliated with Summit Acupuncture. These procedures may include but are not limited to acupuncture, moxibustion, cupping, qua, electric stimulation and tui na. I have discussed the nature and purpose of my treatment with the acupuncturist.

I have been informed that acupuncture is a safe form of treatment, but that it may have side effects including bruising, numbness and tingling near needle sites, nausea, dizziness and fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include nerve damage, organ puncture and miscarriage. Infection is another possible risk, although Summit Acupuncture uses sterile single use disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion.

I will notify my practitioner if I become pregnant.

I do not expect my practitioner to be able to anticipate and explain all possible risks of treatment. I wish to rely on my practitioner to exercise judgment during the course of treatment that the practitioner thinks at the time, based upon the facts known to him/her, is in my best interests.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and health benefits of acupuncture,20 and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition, and for future condition(s) for which I seek treatment.

\_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date



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**PATIENT REVIEW REGARDING DIAGNOSTIC EXAM**

**OPTION 1:**

I have received a diagnostic exam by a physician or chiropractor within the last 6 months regarding the condition for which I am seeking treatment.

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Patient Signature

Date

**OPTION 2:**

I have **NOT** received a diagnostic exam by a physician or chiropractor in the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

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Patient Signature

Date

---

Licensed Acupuncturist Signature

Date

Cc: Patient File  
Provided to patient